

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03708

CERTIFICATE OF DEATH

03703

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First JOHN	Middle RUSSELL	Last CARROLL	2a. DATE OF DEATH Month March Day 29 Year 1969	2b. HOUR 6 A. M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH November 19, 1893		6. AGE (In years last birthday) 75 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Caroline		
10. CITY OR TOWN OF DEATH Federalsburg	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 206 East Central Avenue		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Postmaster		12b. KIND OF BUSINESS OR INDUSTRY Postoffice
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Caroline	13c. CITY OR TOWN Federalsburg	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 206 East Central Avenue	
14. FATHER'S NAME First Harry	Middle M.	Last Carroll	15. MOTHER'S MAIDEN NAME First Carrie	Middle L.	Last Davis
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown Yes	16b. SOCIAL SECURITY NO. WW I	17. INFORMANT Mrs. Edith V. Carroll, Federalsburg, Md.	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Atherosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF stating the underlying cause (c) Generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF 30 yrs					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Carcinoma of bladder					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from Aug 3, 1959, to Mar 29, 1969, that (I) (we) lost saw the deceased alive on Mar 24, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>H. R. Rapnell</i>	DEGREE	ATTENDING PHYS.	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 3-31-69
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS H. R. Rapnell, M.D.				
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE April 1, 1969	23c. NAME OF CEMETERY OR CREMATORIAL Hill Crest Cemetery	23d. LOCATION (City or Town) Federalsburg	(County) Maryland	(State)
24. FUNERAL DIRECTOR Frampton Funeral Home, Federalsburg, Maryland	ADDRESS from Frampton		25a. REC'D BY REGISTRAR APR 7 1969	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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000 7 856

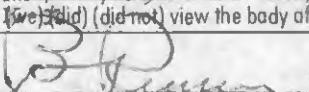
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03704

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED-NAME (Type or print)		First SOPHIA	Middle REBECCA	Last CHRISTOPHER	2a. DATE OF DEATH Month March	Day 23	Year 1969	2b. HOUR M Noon			
3. SEX Female		4. RACE White		S. DATE OF BIRTH December 25, 1894	6. AGE (In years last birthday) 74		IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0	HOURS 0	MIN 0	
7a. BIRTHPLACE (State or foreign country) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Caroline						
10. CITY OR TOWN OF DEATH Bethlehem		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) AT Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housework		12b. KIND OF BUSINESS OR INDUSTRY Home					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland		13b. COUNTY Caroline		13c. CITY OR TOWN Bethlehem	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER					
14. FATHER'S NAME First George W. Anstine		Middle 	Last 	15. MOTHER'S MAIDEN NAME First Elizabeth Norris		Middle 	Last 				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT C. Wesley Christopher, Baltimore, Maryland		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)		Chronic Congestive Heart Failure							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-4 mos		
4122 Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive cardiovascular disease							15 yrs		
		DUE TO, OR AS A CONSEQUENCE OF (c) Generalized arteriosclerosis							20 yrs		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) Mild c'ntrol Diabetes mellitus											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town		County	State			
22a. I certify that (I) (this hospital), attended the deceased from 10/25/69 to 3/27/69 , 19 69 , that (I) (we) last saw the deceased alive on 3/27/69 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we held) (did not) view the body after death.											
22b. SIGNATURE 		DEGREE M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 3/27/69					
22d. PHYSICIAN'S NAME (Type) Harold B. Flummer M.D.		22e. ADDRESS Preston Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE March 26, 1969		23c. NAME OF CEMETERY OR CREMATORIAL Junior Order Cemetery		23d. LOCATION (City or Town) Preston, Maryland		(County)	(State)		
24. FUNERAL DIRECTOR Frampton Funeral Home		ADDRESS Federalburg, Maryland		25a. RECEIVED BY REGISTRAR MAR 28 1969		25b. REGISTRAR'S SIGNATURE 					
VR A15 30M REV. 1968											

00760

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil ^{in Step 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.}

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03705

03710

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)	First Gertrude	Middle	Last Dreher	2a. DATE KNOWN OF ESTI- MATED	Month 3	Day 23	Year 69	2b. HOUR 6P M					
3. SEX Female	4. RACE White	S. DATE OF BIRTH 6-9-1882	6. AGE (In years and birthday) 86 YRS.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	HOURS	MIN.	2c. DATE PRONOUNCED DEAD Month 3	2d. HOUR Day 23	Year 69	19	7	45PM
7d. BIRTHPLACE (State or foreign country) New Jersey	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Caroline	Md.						
10. CITY OR TOWN OF DEATH Federalsburg	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) R.D. # 1				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife				12b. KIND OF BUSINESS OR INDUSTRY None				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before Admission) STATE Maryland	13b. COUNTY Caroline	13c. CITY OR TOWN Federalsburg	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Rt. \$ 1 Box 109									
14. FATHER'S NAME No Record	First	Middle	Last	15. MOTHER'S MAIDEN NAME No Record	First	Middle	Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)				17. INFORMANT Martha Gifford	ADDRESS Federalsburg, Md.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MoE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4123 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerized arteriosclerosis													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) none													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Harold B. Plummer</i> EXAMINER'S NAME (Type) Harold B. Plummer M.D.													
23a. BURIAL, CREMATION, ~ REMOVAL (Specify) Burial		23b. DATE 3-26-69		23c. NAME OF CEMETERY OR CREMATORIAL Holy Cross		23d. LOCATION (City or Town) Greensboro, Caroline, Md.		(County)	(State)				
24. FUNERAL DIRECTOR J.E. Boulaire		ADDRESS Greensboro, Caroline, Md.				25a. RECD BY REGISTRAR APR 1 1969	25b. REGISTRAR'S SIGNATURE Charles Judge						

0170

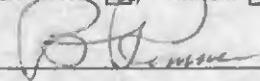
FOR STATE
HEALTH DEPT.

03711

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03706

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or Print)	First LAURA	Middle JANE	Last JOHNSON	2a. DATE KNOWN OF ESTI. DEATH MATED <input checked="" type="checkbox"/>	Month March	Day 3	Year 1969	2b. HOUR M
3. SEX Female	4. RACE Negro	5. DATE OF BIRTH June 1, 1889	6. AGE (In years last birthday) 79 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month March		
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Caroline	2d. HOUR D	
10. CITY OR TOWN OF DEATH Federalsburg	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 113 Sunshine Avenue			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Domestic			12b. KIND OF BUSINESS OR INDUSTRY Domestic	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Caroline	13c. CITY OR TOWN Federalsburg	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 113 Sunshine Avenue				
14. FATHER'S NAME Henry	First Middle Lipson	Last	15. MOTHER'S MAIDEN NAME Mary	First (maiden name unknown)	Middle	Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) No	16b. SOCIAL SECURITY NO. 079-24-9983	17. INFORMANT Mrs. Robert Briggs, Hurlock, Md., RFD	ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left hemiplegia 4121 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) cerebral Hemorrhage DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c) Hypertensive arteriosclerotic Heart Disease 16 yrs						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes mellitus						hours		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
ACTUAL SIGNATURE 						M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) Marcel B. Plummer						22b. DATE SIGNED 3/11/69		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE March 8, 1969	23c. NAME OF CEMETERY OR CREMATORIAL Federal Hill Cemetery	23d. LOCATION (City or Town) Federalsburg	County Maryland	(State)		
24. FUNERAL DIRECTOR Frampton Funeral Home, Federalsburg, Maryland		1. ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE K. Charles Young	DATE MAR 14 1969			
VR A15ME (5) 10M REV 1/68								

1951.11

中華人民共和國郵政部發行
郵票圖案說明：郵票圖案說明：郵票圖案說明：郵票圖案說明：

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

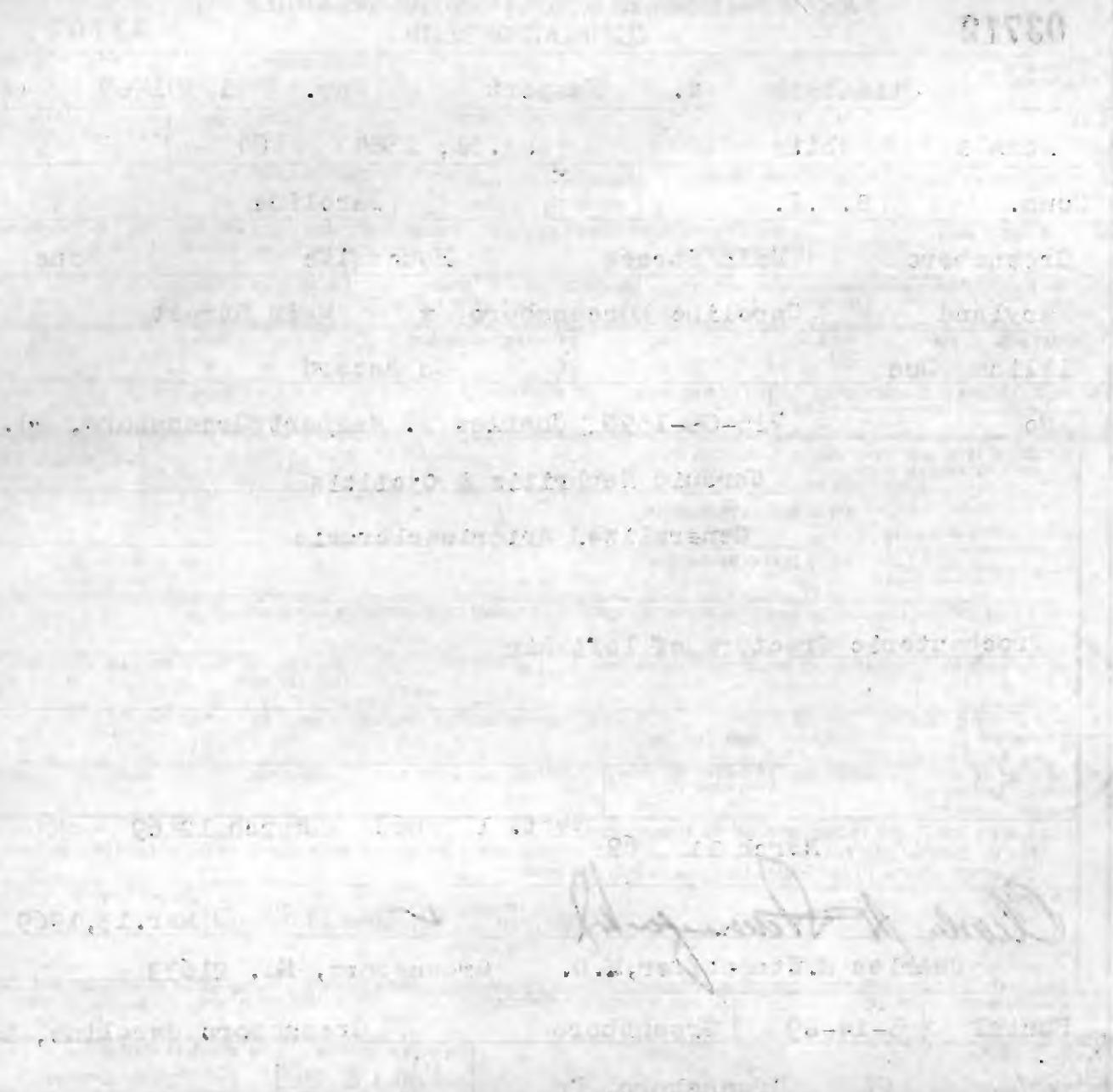
03707

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. If any event, within 72 hours after death.

03712

1. DECEASED NAME (Type or print)	First Elizabeth	Middle W.	Last Kespert	2a. DATE OF DEATH Month Mar. Day 12 Year 1969	2b. HOUR 4A.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH Aug. 31, 1884		6. AGE (In years lost birthday) 84	IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN 0
7a. BIRTHPLACE (State or foreign country) Conn.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Caroline		
10. CITY OR TOWN OF DEATH Greensboro	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Main Street		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Caroline	13c. CITY OR TOWN Greensboro	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER Main Street	
14. FATHER'S NAME First William Dee	Middle	Last	15. MOTHER'S MAIDEN NAME First No Record	Middle	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 715-09-1377	17. INFORMANT Charles W. Kespert	Address Greensboro, Md.		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Nephritis & Cystitis 403 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Generalized Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Trochanteric fracture of left hip					
19a. MEDICAL CERTIFICATION DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from Sept. 1, 1968, to March 12, 1969, that (I) (we) last saw the deceased alive on March 11, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Charles H. Stonesifer, M.D.	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED Mar. 13, 1969	
22d. PHYSICIAN'S NAME (Type) Charles H. Stonesifer, M.D.	22e. ADDRESS Greensboro, Md. 21639				
23a. BURIAL, CREMATION, (Indicate Specific)	23b. DATE 3-14-69	23c. NAME OF CEMETERY OR CREMATORIAL Greensboro	23d. LOCATION (City or Town) Greensboro	(County) Caroline	(State) Md.
24. FUNERAL DIRECTOR J. E. Boules	ADDRESS Greensboro, Md.		25a. REC'D BY REGISTRAR MAR 18 1969	25b. REGISTRAR'S SIGNATURE Charles George	

21760



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03713

03708

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

1. DECEASED NAME (Type or print)	First ROBERT	Middle DAVID	Last NEWTON	2a. DATE OF DEATH MARCH 27 1969	2b. HOUR M
3. SEX M	4. RACE W	5. DATE OF BIRTH MARCH 3, 1909	6. AGE (In years last birthday) 60 YRS.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) PA.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH CAROLINE		
10. CITY OR TOWN OF DEATH DENTON	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOME SHARP RD.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) TROLLEYS	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD	13b. COUNTY CAROLINE	13c. CITY OR TOWN DENTON	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER SHARP RD	
14. FATHER'S NAME First ROBERT	Middle NEWTON	15. MOTHER'S MAIDEN NAME First BERTHA	Middle CLYMER	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO	16b. SOCIAL SECURITY NO.	17. INFORMANT MRS. ROBT. NEWTON DENTON	Address	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>auto myocard infarction</u> <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>coronary thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (c)</p>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 20, 1966</u>, to <u>Mar 11, 1969</u>, that (I) (we) last saw the deceased alive on <u>March 11, 1969</u>, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Ole P. Delyne</u>	DEGREE	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 3/28/69
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE MARCH 30, 1969	23c. NAME OF CEMETERY OR CREMATORIAL DENTON	23d. LOCATION (City or Town) DENTON, CAR. MD.	(County) (State)	
24. FUNERAL DIRECTOR CHARLES MOORE DENTON MD	ADDRESS	25a. REGISTRY REGISTRAR APR 3 1969	25b. REGISTRAR'S SIGNATURE <u>Charles Moore</u>		

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03714

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03709

1. DECEASED NAME (Type or Print)	First WILLIAM	Middle	Last SINGLETON	2a. DATE KNOWN OF ESTI. DEATH MATED	Month March	Day 1	Year 1969	2b. HOUR P.M.			
3. SEX Male	4. RACE Negro	5. DATE OF BIRTH July 28, 1922	6. AGE (in years last birthday) 46 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month March			2d. HOUR 8 A.M.		
7a. BIRTHPLACE (State or foreign country) South Carolina	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED Separated WIDOWED DIVORCED	9. COUNTY OF DEATH Caroline								
10. CITY OR TOWN OF DEATH Preston - Rural		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Near Lanyard			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Day Laborer			12b. KIND OF BUSINESS OR INDUSTRY Canning Factor			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Caroline	13c. CITY OR TOWN Preston	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Near Bethlehem							
14. FATHER'S NAME First Icson	Middle Singleton	Last	15. MOTHER'S MAIDEN NAME First Rachael	Middle Sellers	Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	16b. SOCIAL SECURITY NO. (If yes give way or dates of service) WW II	16c. INFORMANT Claybelle Crummey, East New Market, Md. RFD	ADDRESS								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Labor pneumonia, R.I.</u> DUE TO, OR AS A CONSEQUENCE OF 481X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										22b. DATE SIGNED 3-3-69	
ACTUAL SIGNATURE <u>Peter W. Rieckert</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, City, Town or County)									
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Mar. 13, 1969	23c. NAME OF CEMETERY OR CREMATORIAL Seller's Cemetery	23d. LOCATION (City or Town) Summerville, South Carolina		(County)		(State)				
24. FUNERAL DIRECTOR Frampton Funeral Home, Federalsburg, Maryland	ADDRESS		25a. REC'D BY REGISTRAR MAR 14 1969	25b. REGISTRAR'S SIGNATURE <u>Charles George</u>							

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